In the Matter of

Linda Watkins, Widow of
Claude W. Watkins, Deceased,
Claimant

v.

U.S. Steel Mining Company,
Employer

and

Director, Office of Workers' Compensation Programs,
Party-In-Interest

Date Issued: 9-5-00
Case No. 2000-BLA-425

Appearances:

Frederick K. Muth, Esquire
For the Claimant

Howard G. Salisbury, Jr., Esquire
For the Employer

Before: Linda S. Chapman
Administrative Law Judge

DECISION AND ORDER
GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of

their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was held before the undersigned on June 20, 2000 in Pipestem, West Virginia, at which all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations, Parts 410, 718, 725, and 727.

I have based my analysis on the entire record, including the transcript, exhibits, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.[1]

JURISDICTION AND PROCEDURAL HISTORY

On January 6, 1994, January 26, 1995, and March 17, 1997, Claude W. Watkins, a former coal miner, filed applications for benefits under the Act (DX 20-1, DX 21-1, DX 22-1), which were denied by the Office of Workers' Compensation Programs on June 24, 1994 (DX 20-14), October 24, 1995 (DX 21-12), and July 31, 1997 (DX 22-11), respectively. The miner did not appeal the denial, nor otherwise pursue the first two claims. On October 8, 1997, Mr. Watkins, through counsel, withdrew his appeal of the third claim (DX 22-18). No further claim was ever filed by the miner. Accordingly, all of the above-referenced miner's claims are administratively closed and deemed to be finally denied (DX 24).

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On April 4, 1999, Claude W. Watkins passed away (DX 7). Shortly thereafter, on June 2, 1999, his widow, Linda G. Watkins, the Claimant, filed an application for survivor's benefits (DX 1), which was granted by the Office of Workers' Compensation (DX 15,18,19). Following the Employer's timely controversion (DX 16), this matter was referred to the Office of Administrative Law Judges on January 31, 2000 (DX 24).[2]

This claim was heard in Pipestem, West Virginia, on July 20, 2000.

ISSUES PRESENTED

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[1] "TR" refers to the hearing transcript; "DX" refers to those exhibits in the record designated as "Director's Exhibits;" and "EX" refers to the Employer's exhibits submitted in connection with this proceeding.

[2]The merits of the miner's claims are not under consideration herein, and thus the determination in this claim will not affect the denial of the miner's prior claims.

The issues contested by the Employer are:

1. Whether the miner, Mr. Claude W. Watkins, had pneumoconiosis;
2. Whether the miner's pneumoconiosis arose out of his coal mine employment;
3. Whether the miner's death was due to pneumoconiosis.

(TR 7-9, DX 23).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The miner, Claude W. Watkins, was born on June 30, 1941, and died on April 4, 1999 (DX 7). He married his wife, Linda G. Watkins (nee Pennington), on October 4, 1961 (DX 6). At the time of his death, the miner was married and living with his wife, who has not remarried since his death (TR 10). Accordingly, the Employer conceded, and I find, that the Claimant is the eligible survivor of the deceased miner (TR 9). She has no dependents for the purpose of possible augmentation of benefits under the Act (TR 10-11).

The Claimant testified that prior to her husband's death, Mr. Watkins "had a very hard time breathing, he was very weak, he coughed a lot." She also stated that her husband was treated by Dr. Harden for various medical problems, including diabetes, black lung, strokes, and heart trouble. Although the Claimant knew that her husband had filed a State claim for occupational pneumoconiosis, she did not remember whether he received any State benefits (TR 12). The record reflects a State award, dated January 9, 1981, based upon findings by the State Occupational Pneumoconiosis Board on October 21, 1980 of a 10% permanent partial disability due to occupational pneumoconiosis (DX 20-3, DX 21-3, DX 22-3).

Length of Coal Mine Employment

The Employer conceded, and the record supports my finding that Mr. Watkins engaged in coal mine employment for at least 25 years (DX 23; TR 8).

Responsible Operator

Under the regulations, liability for benefits under the Act is assessed against the most recent coal mine operator which meets the requirements set out in 20 C.F.R. §§725.492, 725.493.

The Employer no longer contests its status as the responsible operator (TR 8-9). As the record clearly indicates that the Employer was the last operator for whom Mr. Watkins worked as a coal miner for a period of at least one year, I find that U.S. Steel Mining Company is properly

designated as the responsible operator for this claim.

APPLICABLE STANDARD

The Regulations at 20 C.F.R.§ 718 apply to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. Because the Claimant filed her survivor's claim after January 1, 1982, 20 C.F.R. § 718.205(c) applies to this claim.

The regulations provide that a survivor is entitled to benefits only where the miner died due to pneumoconiosis. 20 C.F.R. § 718.205(a). The Claimant must establish that: (1) the decedent was a coal miner; (2) the decedent suffered from pneumoconiosis at the time of his death; (3) the decedent's pneumoconiosis arose out of his coal mine employment; and (4) the decedent's death was caused by pneumoconiosis or pneumoconiosis was a substantially contributing cause or factor leading to his death. All elements of entitlement must be established by a preponderance of the evidence. *Strike v. Director, OWCP,* 817 F.2d 395, 399 (7th Cir. 1987). The survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. 718.205(c). If the principal cause of death is a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death. 20 C.F.R. 718.205(c)(4).

The Board has held that death will be considered to be due to pneumoconiosis where the cause of death is significantly related to or significantly aggravated by pneumoconiosis. *Foreman v. Peabody Coal Co.,*8 B.L.R. 1-371 (1985). The United States Court of Appeals for the Fourth Circuit, in which the instant case arises, has held that pneumoconiosis is a substantially contributing cause of death if it hastens, even briefly, the miner's death. *See Shuff v. Cedar Coal Co.,* 967 F.2d 977 (4th Cir. 1992), *cert. denied,* 113 S.Ct. 969 (1993). *See also Lukosevicz v. Director, OWCP,* 888 F.2d 1001 (3rd. Cir. 1989); *Brown v. Rock Creek Mining Corp.,* 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); *Peabody Coal Co. V. Director, OWCP,* 972 F.2d 178 (7th Cir. 1992).[3]

The Board has held that in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to the disease under § 718.205. *Trumbo v. Reading Anthracite Co.,* 17 B.L.R. 1-85 (1993).

Existence of Pneumoconiosis

[3]Appellate jurisdiction lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP,* 12 BLR 1-200 (1989)(en banc). Here, the miner last worked in West Virginia (Fourth Circuit), even though the Employer is located in Pennsylvania (Third Circuit) (DX 2).

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director,* OWCP, 9 BLR 1-36 (1986); *Hucker v. Consolidation Coal Co.,*9 B.L.R. 1-137 (1986). The Board has held that the burden of proof is met under § 718.203(c) where "competent evidence establish(es) that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-1101-112 (1987). Specifically, the record must contain *medical* evidence to demonstrate causation. *Baumgartner v. Director, OWCP,* 9 BLR 1-65, 1-66 (1986)(administrative law judge cannot infer causation based solely upon claimant's employment history); *Tucker v. Director, OWCP,* 10 BLR 1-35, 1-39 (1987)(it was error for the administrative law judge to rely solely upon lay testimony to find causation established).

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a).[4]

X-ray Evidence

The regulation at 20 C.F.R. 718.202(a)(1) requires that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications.[5] *Roberts v. Bethlehem Mines Corp.,* 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.,* 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-

[4] The case file does not contain any biopsy or autopsy evidence. Thus, pneumoconiosis cannot be established under §718.202(a)(2). Similarly, the presumptions contained at §§718.304, 718.305, and 718.306 are inapplicable. Therefore, the presence of pneumoconiosis cannot be established pursuant to §718.202(a)(3). Accordingly, these methods of demonstrating pneumoconiosis will not be further discussed.

[5] A "B-reader" is a physician, but not necessarily a radiologist, who has successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" means that the physician is "certified" in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a Board-certified radiologist. *Herald v. Director, OWCP*,BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished).

The following chest roentgenogram evidence is in the record.

Exhibit No.	Date of Film	Physician	Interpretation
DX 20-12	Unknown[6]	Hale	Category 1, p
DX 20-9,12	2/4/94	Pathak, B, BCR	1/2, p, q
DX 20-10	2/4/94	Sargent, B, BCR	no pneumoconiosis
DX 20-11	2/4/94	Francke, B, BCR	completely negative
DX 21-9	7/28/95	Ranavaya, B	1/2, p, q
DX 21-10	7/28/95	Gaziano, B	1/2, q, q
DX 22-9	5/23/97	Ranavaya, B	1/2, p, q
DX 22-10	5/23/97	McFarland, B, BCR	1/2, s, s

In addition, the case file contains numerous descriptive interpretations of various chest x-rays which were administered during Mr. Watkins' treatment and hospitalizations from 1997 until his death (DX 8). Although many of the x-rays reveal some abnormalities, none make any specific findings of pneumoconiosis. Nor do any of these reports meet the classification requirements set forth in § 718.102(b). I do not consider them to be positive or negative.

There are four x-rays that were interpreted according to the ILO classification standards of the regulations. The first of these was by Dr. Daniel Hale, whose qualifications are unknown. Further, although his three line letter reporting his interpretation is dated August 11, 1975, there is no indication of the date the x-ray was taken. Nor is it entirely clear what he means by "Category 1." Although Dr. Hale apparently concluded that Mr. Watkins had pneumoconiosis on the basis of this x-ray, I do not give it significant weight.

The next x-ray, performed on February 4, 1994, was interpreted by Dr. Pathak, who is dually qualified, as positive. However, two other physicians, both dually qualified, found it to be negative. Given the equal balance of credentials, I find that the two negative interpretations outweigh Dr. Pathak's positive interpretation.

However, by July 28, 1995, two B readers found Mr. Watkins' x-ray to be positive. In addition, two physicians, one dually qualified, and one a B reader, found that Mr. Watkins' May 23, 1997 x-ray was positive. Giving more weight to the uncontroverted positive readings of the two most recent x-rays, I find that on balance, the Claimant has established that Mr. Watkins had

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[6]The date of this film is not listed. However, the date of the report is August 11, 1975 (DX 20-12).

pneumoconiosis by a preponderance of the x-ray evidence.

The Fourth Circuit has recently ruled that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether a miner suffered from pneumoconiosis. *Island Creek Coal Co. v. Compton*, ___ F.3d ___, 2000 WL 524798 (4th Cir. 2000). Thus, I will also consider the other methods for establishing the existence of pneumoconiosis.

There is no biopsy or autopsy evidence in the record. Nor do the presumptions at §§ 718.304, 305, or 306 apply. However, the record does contain medical opinion evidence.

Medical Opinion Evidence

The Claimant can also establish that Mr. Watkins suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See, Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra.* Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder of fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.*, 9 B.L.R. 1-106 (1986).

In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probative weight to the most recent report. *Clark v. Karst-Robbins Coal Company*, 12 BLR 1-149 (1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. *Thorn v. Itmann Coal Company*, 3 F.3d 713 (4th Circuit 1993). Finally, a medical opinion may be given little weight if it is vague or equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Circuit 1995) and *Justice v. Island Creek Coal Company*, 11 BLR 1-91 (1988).

The relevant medical opinions, the miner's death certificate findings, and various hospital records are summarized below.

Hospital Records

The record reveals that Mr. Watkins was treated on multiple occasions for numerous medical problems at Duke University Medical Center (DX 17), Bluefield Regional Medical Center (DX 8), and Maples Health Care (DX 8).

Records from the Duke University Medical Center indicate that Mr. Watkins' history of diabetes mellitus dated back to 1975, and that he was first hospitalized for heart disease in 1980, when he was told that he had a myocardial infarction. In 1981, Mr. Watkins underwent his first catheterization and was treated for minor coronary artery disease. In April 1990, Mr. Watkins underwent another cardiac catheterization. In May 1992, he was hospitalized, with an initial diagnosis of diabetes mellitus with retinopathy, neuropathy, and possible diabetic neuropathic cachexia; organic heart disease with coronary artery disease and arrhythmias, status post MI, status post angioplasty; hyperlipidemia; chronic obstructive pulmonary disease with tobacco abuse and a history of coal mining; weight loss; early satiety; cerebrovascular disease status post apparent TIA; peripheral vascular disease; depression; status post hemorrhoidectomy, appendectomy, coronary angioplasty, multiple skin biopsies; and family history of coronary artery disease, stroke, diabetes, hypertension, and cirrhosis (DX 17).

Records from the Bluefield Regional Medical Center show that Mr. Watkins was treated on numerous occasions from 1994 through 1999 (DX 8). Coal worker's pneumoconiosis was specifically listed among various discharge diagnoses on several occasions, such as the July 20, 1994, October 5, 1997, and July 2, 1998 discharge summaries. It was also listed under "Impressions," in a consultation report, dated July 5, 1998. However, many other hospital records do not contain a specific diagnosis of pneumoconiosis. Nevertheless, other respiratory or pulmonary conditions are often listed, such as chronic obstructive pulmonary disease, chronic airway obstruction, and pneumonia. A July 5, 1997 CT scan of Mr. Watkins' thorax showed minimal interstitial fibrotic scarring and COPD.

In addition, the hospital records confirm that Mr. Watkins suffered from numerous other medical conditions, many of which were related to his cardiac problems (DX 8). The last hospital admission at Bluefield Regional Medical Center occurred on January 30, 1999, when Mr. Watkins complained of "altered mental status." Although his past medical history included severe COPD, physical findings on examination showed that the lungs were clear. The overall assessment by the attending physician was that Mr. Watkins had an altered mental status, secondary to severe constipation/obstipation, although the physician could not rule out a stroke. The attending physician noted that Mr. Watkins had a history of recurrent strokes, as well as multi-infarct dementia. He also had organic heart disease, a history of chronic congestive heart failure, angina, and PAT. Mr. Watkins also suffered from chronic depression, insulin dependent diabetes mellitus, and severe peripheral vascular disease.

Mr. Watkins had acute visits to the Maples Health Care on March 11, 1999 and March 18, 1999, respectively (*i.e.*, only a few weeks before his death) (DX 8). Physical examination on March 11, 1999 revealed rhonchi in the right base and anterior chest with occasional rales; no wheezing was noted. The attending physician assessed him with probable aspiration pneumonia, and vomiting, subsided. (DX 8). In pertinent part, physical findings on the March 18, 1999 examination showed occasional rhonchi, with an assessment of stage I decubitis versus candidiasis, congestive heart failure (CHF), and multi-infarct dementia, secondary to multiple strokes (DX 8).

Dr. E. Rhett Jabour

Dr. E. Rhett Jabour examined Mr. Watkins on February 9, 1994 (DX 20-7). Dr. Jabour reported his history, subjective complaints, physical findings on examination, a positive chest x-ray 1/2, reading, and nonqualifying pulmonary function studies and arterial blood gases.[7] Based upon the foregoing, Dr. Jabour diagnosed pneumoconiosis and coronary artery disease. He related Mr. Watkins' pneumoconiosis to coal dust and cigarette smoking. He attributed Mr. Watkins' coronary artery disease to ischemic heart disease. Finally, Dr. Jabour opined that Mr. Watkins was 100% impaired, and that 20% of such impairment was due to pneumoconiosis and 80% was due to coronary artery disease (DX 20-7).

Dr. Mohammed I. Ranavaya

Dr. Mohammed I. Ranavaya examined Mr. Watkins on July 8, 1995 (DX 21-7). He reported Mr. Watkins' history, subjective complaints, and physical findings, and administered a chest x-ray, pulmonary function studies, arterial blood gases, and an EKG. Based upon Mr. Watkins' reported history of 28 years of underground coal mine employment and radiological evidence, Dr. Ranavaya diagnosed pneumoconiosis. He also diagnosed coronary artery disease and diabetes mellitus based upon Mr. Watkins' history. Dr. Ranavaya concluded that Mr. Watkins' had a mild impairment, as reflected by the pulmonary function studies (DX 21-7).

Dr. Ranavaya conducted a second pulmonary evaluation of Mr. Watkins on May 23, 1997 (DX 22-7). He again reported the miner's history, subjective complaints, and physical findings, and administered a chest x-ray, a resting arterial blood gas study, and an EKG. He did not perform pulmonary function studies, noting that Mr. Watkins did not feel well, and was status post multiple cerebrovascular accidents. For the same reasons, no exercise blood gas test was administered. Based

[7]Although the clinical studies were nonqualifying, some of the results were abnormal (DX 20-6, DX 20-8).

upon Mr. Watkins' 25-year coal mine employment history and radiological evidence, Dr. Ranavaya again diagnosed pneumoconiosis, which he attributed to Mr. Watkins' occupational dust exposure in the mines. Dr. Ranavaya also diagnosed coronary artery disease, and status post cerebral vascular accident. Dr. Ranavaya indicated that Mr. Watkins' pulmonary impairment was mild, and in and of itself would not prevent him from performing his last usual coal mine employment.

Dr. Martin Sherer

Dr. Martin Sherer issued a cursory report, dated December 4, 1995 (DX 21-14), the full text of which is as follows:

> Mr. Watkins has been under my care for the past seven years. He is a former coal worker. He has impairments secondary to his coal mining work in addition to this and has had recurrent small strokes which has impaired his right side, there being decreased strength in the right arm and right leg. In addition to this, he has recurrent angina pectoris and ischemic heart disease. Mr. Watkins' black lung disease is resulting in chronic hypoxemia which is clearly an aggravating factor for his small strokes and his ischemic heart disease. It is my considered opinion that Mr. Watkins is totally disabled based upon physical examination and history.

(DX 21-14).

Dr. William B. Harden

Dr. William B. Harden, who was Mr. Watkins' attending physician (TR 11-12), issued a cursory report, dated Ma 27, 1999 (DX 9). The full text is as follows:

> Mr. Watkins was a patient at The Maples Long Term Care Facility. He had multiple medical problems, including recurrent strokes. However, he died from what was felt to be a Methicillin Resistant Staphylococcus Aureus (MRSA) Pneumonia and Bacteremia. He was treated aggressively with the three antibiotics including one that would be directed specifically for MRSA. However, the patient remained bacteremic, his no code was honored, and he subsequently expired. The family is concerned about his relationship with his Black Lung, and his final death of Pneumonia. The Black Lung was certainly a coexistent disease, and I would state that it was a risk factor in his recovering from any Pneumonia.

In a supplemental report, dated August 25, 1999, Dr. Harden responded to a question posed by the Claims Examiner regarding whether pneumoconiosis hastened Mr. Watkins' death (DX 10). He stated:

> I am in receipt of your letter and copies of record for Claude Watkins. Mr. Watkins was basically admitted to The Maples with recurrent strokes. He had a history of Coal Worker's Pneumoconiosis, and recurrent pneumonias. He had a major stroke prior to his death, and subsequently developed pneumonia. All of the cultures were positive for Methicillin Resistant Staphylococcus Aureus (MRSA). As I said on his death certificate, I feel his cause of death was MRSA pneumonia and hastened by having a stroke to the point where he could not cough, deep breath, and clear his secretions. Any chronic lung disease, such as Coal Worker's Pneumoconiosis would have increased his risk of mortality and morbidity with pneumonia.

As set forth in Dr. Harden's supplemental report, the death certificate, signed on April 7, 1999 by Dr. Harden, states that the immediate cause of Mr. Watkins' death was "MRSA Pneumonia." Cerebrovascular disease is listed as an underlying cause. The death certificate does not list pneumoconiosis as an underlying cause or other significant condition contributing to Mr. Watkins' death (DX 7).

Dr. Kirk E. Hippensteel

Dr. Kirk E. Hippensteel, a B-reader and Board-certified pulmonary specialist, issued a report dated June 19, 2000 (EX 1). Dr. Hippensteel did not examine Mr. Watkins, but he reviewed the available medical data in detail. Based upon his review, Dr. Hippensteel concluded that there was not sufficient evidence of pneumoconiosis. He based his opinion on the fact that the majority of the x-ray interpretations were negative. He noted that Dr. Jabour and Dr. Ranavaya based their conclusions that Mr. Watkins had pneumoconiosis on a positive interpretation of his x-ray, which was a "distinctly minority opinion," with no other data to support their opinions other than Mr. Watkins' history of coal dust exposure. Dr. Hippensteel noted that Mr. Watkins' pulmonary function was nearly normal in tests performed in 1992, showing that he had no significant impairment from any type of lung disease, and from a pulmonary standpoint, could return to his previous job in the mines. Mr. Watkins continued to smoke for many years, and developed arteriosclerotic disease in his brain and heart, unrelated to his previous coal dust exposure.

Dr. Hippensteel noted that although some hospital admission notes reflect pneumoconiosis as a diagnosis, it was not included as a diagnosis in many of the discharge summaries, showing that pneumoconiosis was not considered a significant problem even by those physicians who included it in

their initial diagnosis.

Dr. Hippensteel felt that even if it were concluded that Mr. Watkins had coal workers' pneumoconiosis, the opinions of Dr. Sherer and Harden about the relationship of pneumoconiosis to Mr. Watkins' death are invalid. Dr. Hippensteel agreed with Dr. Harden that Mr. Watkins' died of aspiration pneumonia and cerebrovascular disease. He felt that these problems were associated with multiple strokes and difficulty handling food and secretions, which required the placement of a feeding tube. These problems did not result from coal workers' pneumoconiosis. Furthermore, the objective evidence established that Mr. Watkins did not suffer significant pulmonary impairment. Dr. Hippensteel felt that Mr. Watkins would have died at the same time and from the same problems if he had never set foot in a coal mine.

Discussion

Dr. Jabour and Dr. Ranavaya examined Mr. Watkins for the specific purpose of determining if he had pneumoconiosis. Both performed an array of clinical testing, and concluded, based on their positive interpretations of Mr. Watkins' x-ray, as well as his history of coal mine employment, that he had pneumoconiosis. I find that their opinions are well-reasoned and supported by the evidence of record.

Both Dr. Harden and Dr. Sherer, Mr. Watkins' treating physicians, reported that he had pneumoconiosis. However, neither provided any clinical or laboratory results to support their opinions, which appear to be based solely on the fact that Mr. Watkins' worked as a coal miner. I find that their opinions are not well-documented, and I do not give them significant weight.

Similarly, the notations in various hospital records of Mr. Watkins' history of pneumoconiosis are not supported by any clinical or laboratory testing, and thus, I do not accord them significant weight.

Dr. Hippensteel concluded, based on his review of Mr. Watkins' records, that he did not have pneumoconiosis. However, he relied on what he characterized as a majority of negative interpretations of Mr. Watkins' x-rays.[8] As I have found that the x-ray evidence establishes the existence of

[8]Dr. Hippensteel considers the x-rays that were performed while Mr. Watkins was in the hospital to be negative. As they were not performed for the purpose of evaluating the presence of pneumoconiosis, and were not read under ILO classification standards, I consider them to be neutral - neither positive nor negative.

pneumoconiosis, this detracts from the weight I am willing to accord to Dr. Hippensteel's conclusions. And while Dr. Hippensteel criticizes Dr. Jabour and Dr. Ranavaya for concluding that Mr. Watkins had pneumoconiosis based on their positive interpretation of his x-rays without supporting data other than his history of coal dust exposure, he did not explain how the pulmonary function tests he reviewed (which were, in fact, performed by Dr. Jabour and Dr. Ranavaya) supported his conclusions.

Thus, placing greatest reliance on the opinions of Dr. Jabour and Dr. Ranavaya, which are buttressed by my conclusion that the x-ray evidence establishes pneumoconiosis, I find that the Claimant has clearly established by a preponderance of the evidence that Mr. Watkins had pneumoconiosis.

The Claimant must still show that Mr. Watkins' pneumoconiosis was due to his coal mining employment. If a miner is suffering from pneumoconiosis and he worked ten or more years in one or more coal mines, there is a rebuttable presumption under the regulations that pneumoconiosis arose out of coal mine employment. Since Mr. Watkins spent at least twenty five years in coal mine employment, the Claimant is entitled to the presumption. There is no medical evidence in the record to suggest that Mr. Watkins' pneumoconiosis arose out of any other cause. In the absence of sufficient rebuttal evidence, the Claimant has established that Mr. Watkins' pneumoconiosis arose out of coal mine employment.

Death Due to Pneumoconiosis

Benefits are provided under the Act for survivors who died due to pneumoconiosis. 20 C.F.R. § 718.205. The regulations require competent medical evidence which (1) establishes that the miner died due to pneumoconiosis; (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of § 718.304 is applicable.

Although the Board adheres to the standard that the record must demonstrate that "the cause of death is significantly related to or significantly aggravated by pneumoconiosis," *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985), the Third, Fourth, Sixth, and Seventh Circuits hold that pneumoconiosis must merely "hasten" the miner's death in order for a survivor to be entitled to benefits. *Brown v. Rock Creek Mining Corp., supra*; *Peabody Coal Co. v. Director, OWCP, supra*; *Shuff v. Cedar Coal Co., supra*; *Lukosevicz v. Director, OWCP, supra*.

Dr. Harden, who was Mr. Watkins' attending physician at his death, reported that while Mr. Watkins died of pneumonia, his pneumoconiosis was a risk factor in recovering from the pneumonia.

He noted that at the time of his death, Mr. Watkins could not cough or take a deep breath, or clear his lungs of secretions, because of the major stroke he suffered just before he died. Dr. Harden felt that any chronic lung disease, such as pneumoconiosis, would have increased his risk of dying from pneumonia.[9]

Dr. Harden's conclusion are buttressed by Dr. Sherer, Mr. Watkins' treating physician, who indicated as far back as 1995 that Mr. Watkins' chronic hypoxemia, caused by his pneumoconiosis, was an aggravating factor in his recurrent small strokes and ischemic heart disease.

Dr. Hippensteel, on the other hand, has concluded that even if it were found that Mr. Watkins had pneumoconiosis, Dr. Harden and Dr. Sherer are incorrect. Dr. Hippensteel did agree with Dr. Harden, that Mr. Watkins died of aspiration pneumonia and cerebrovascular disease. He noted that Mr. Watkins' course was complicated by his multiple strokes, and subsequent difficulty in swallowing and clearing his secretions. Apparently, Dr. Hippensteel felt that since pneumoconiosis did not cause the pneumonia or strokes that were the direct cause of his death, and he did not have a significant pulmonary impairment, pneumoconiosis could not have been a factor in his death. However, he did not explain why he categorically ruled out Mr. Watkins' pneumoconiosis, and its resultant hypoxemia, as contributing factors in Mr. Watkins' ability to fight off the bacterial pneumonia. Nor is it necessary that Mr. Watkins have suffered "significant" impairment from pneumoconiosis in order for it to contribute to or hasten his death. The medical evidence of record establishes that Mr. Watkins suffered from some degree of pulmonary impairment due to pneumoconiosis during his lifetime. As Dr. Harden pointed out, any chronic lung disease would have increased his risk of dying from pneumonia. Thus, I find that Dr. Hippensteel's conclusions on this issue, that the pneumoconiosis he did not believe existed did not play a part in his death, are not well-reasoned or supported, and I accord them little weight.

Placing greatest reliance on the opinion of Dr. Harden, Mr. Watkins' attending physician at the time of his death, as buttressed by the earlier opinion of Dr. Sherer, Mr. Watkins' treating physician, I find that the Claimant has established by a preponderance of the evidence that Mr. Watkins death was due, at least in part, to pneumoconiosis.

CONCLUSION

[9]Although I have found that Dr. Harden's opinion on the existence of pneumoconiosis is not entitled to great weight, as Dr. Harden did not provide supporting medical evidence, I find that his opinion as the the effect of Mr. Watkins' pneumoconiosis on his death is probative, as Dr. Harden was Mr. Watkins' attending physician at his death.

I find that the Claimant has established the existence of pneumoconiosis by a preponderance of the evidence, and that pneumoconiosis was a substantially contributing cause or factor leading to Mr. Watkins' death or that his death was caused by complications of pneumoconiosis.

ORDER

It is ordered that the claim of Linda G. Watkins for benefits as the widow of Claude W. Watkins under the Black Lung Benefits Act is hereby GRANTED. It is further ordered that the Employer, U.S. Steel Mining Company, shall pay to Mrs. Watkins, as the survivor of Mr. Watkins, all benefits to which she is entitled under the Act.

ATTORNEY FEES

An application by claimant's attorney for approval of a fee has not been received. Thirty days is hereby allowed to claimant's counsel for submission of such an application. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. The parties have ten days following receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

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LINDA S. CHAPMAN

Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601,Washington, D.C. 20013-7601. *A copy of a Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2605, Washington, D.C. 20210.*